a minimum of six (6) months of historical data, of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. Any new rate resulting from this additional review shall be effective on the first day of the month following the submission of data to the office.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an additional rate review.

FOOTNOTE TO SECTION 6(d) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: EXAMPLES OF SITUATIONS WHERE THE STATE HAS ALLOWED RATE REVIEWS AS PROVIDED FOR IN THIS SECTION INCLUDE BUT ARE NOT LIMITED TO: (a) OBRA 87 LEGISLATION, (b) FEDERAL MINIMUM WAGE INCREASES, (c) PROMULGATION OR PASSAGE OF FEDERAL RULES OR LAWS THAT INCREASE REQUIREMENTS IMPOSED BY SURVEY AND CERTIFICATION ON ICF/MR.

(e) When changes to historical costs meet the requirements of section 5 of this rule, this section, and section 7 of this rule and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the maximum allowable annual rate increase limitation, adjusted by the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using the actual occupancy level for existing beds, plus, where appropriate, those added census days needed to project the census in the additional beds in the following manner:

(1) For large ICFs/MR, the greater of:

(A) ninety-five percent (95%) of total beds available; or

(B) the occupancy the provider could reasonably anticipate for the additional beds.

(2) For CRFs/DD, the greater of:

(A) ninety percent (90%)of total beds available; or

(B) the occupancy the provider could reasonably anticipate for the additional beds.

FOOTNOTE TO SECTION 6(e)(1 & 2)(B) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: PROVIDERS ARE REQUIRED UPON REQUEST, TO JUSTIFY CENSUS IN ADDITIONAL BEDS AND SHOW THAT CENSUS PROJECTIONS ARE ARRIVED AT IN ACCORDANCE WITH ACCEPTED ESTIMATING PRACTICES AS RECOGNIZED BY THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS, AND ARE IN CONFORMITY WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES. IN ADDITION, PROJECTED PROVIDER CENSUS IS MEASURED FOR REASONABLENESS AGAINST THE PROVIDER'S HISTORICAL CENSUS FIGURES IN PREVIOUSLY EXISTING BEDS, FACILITY HISTORICAL OCCUPANCY LEVELS, AND ANNUAL BED NEED PROJECTIONS AS PUBLISHED BY THE DEPARTMENT OF HEALTH IN CONJUNCTION WITH INDIANA'S CERTIFICATE OF NEED PROGRAM.

In no event shall the occupancy used to calculate the capital return factor be less than ninety-five percent (95%) of total beds available for large ICFs/MR and ninety percent (90%) for CRFs/DD. Rate reviews completed under this section will not constitute the provider's additional rate review in one (1) reporting year. This review shall be completed in the same manner as the annual rate review, using all limitations in effect at the time the annual review or base rate review took place, whichever is later. ***(Office of the Secretary of Family and Social Services; 405 IAC 1-12-6)***

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 7. (a) Rate setting shall be prospective, based on the provider's annual or historical financial

report for the most recent completed year. In determining prospective allowable costs, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows.

Median Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(c) For ICFs/MR and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for ICFs/MR and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1) Director of nursing wages.

(2) Administrator wages.

(3) All costs reported in the ownership cost center, except repairs and maintenance.

(4) The capital return factor determined in accordance with sections twelve (12) through seventeen (17) of this rule.

405 IAC 1-12-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient or resident utilization.

(b) Each facility and home office shall be allowed:

(1) one (1) patient or resident care-related automobile; and

(2) one (1) vehicle that can be utilized for facility maintenance or patient or resident support or both uses;

to be included in the vehicle basis for purposes of cost reimbursement under this rule. Vehicle basis means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for all allowable vehicles. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

405 IAC 1-12-9 Criteria limiting rate adjustment granted by office

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate is subject to several limitations. Rates will be established at the lowest of the **four (4)** Limitations listed as follows:

(1) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services. For purposes of this rule, the rates paid by the general public shall not include rates paid by the DDARS.

(2) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(3) Inflated allowable per patient or per resident day costs plus the allowed profit add-on payment as determined by the methodology in Table I.

(4) In no instance shall the approved Medicaid rate exceed the overall rate limit percent (Column A) in Table II, times the average inflated allowable cost of the median patient or resident day.

TABLE I

Profit Add-On

The profit add-on is equal to the percent (Column A) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient or resident day cost, and the ceiling (Column B) times the average inflated allowable per patient or resident day cost of the median patient or resident day. Under no circumstances shall a provider's per patient or resident day profit add-on exceed the cap (Column C) times the average inflated allowable per patient or resident day cost of the median patient or resident day.

	Level of Care	(A) Percent	(B) Ceiling	(C) Cap
	Sheltered living	40%	105%	10%
	Intensive training	40%	120%	10%
	Child rearing	40%	130%	12%
	Nonstate-operated ICF/MR	40%	125%	12%
	Developmental training	40%	110%	10%
	Child rearing with a specialized program	40%	120%	12%
	Small behavior management residences for children	40%	120%	12%
	Basic developmental	40%	110%	10%

Table II

Overall Rate Limit

	Level of Care	(A) Percent
	Sheltered living	115%
	Intensive training	120%
	Child rearing	130%
	Developmental training	120%
	Child rearing with a specialized program	120%
	Small behavior management residences for children	120%
	Basic developmental	120%
	Nonstate-operated ICF/MR	107%

Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) The per diem rate shall be an all-inclusive rate. The office shall not set a rate for more than one (1) level of care for each CRF/DD provider.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient or resident care costs shall be clearly identified.

(c) The provider shall report as patient or resident care costs only costs that have been incurred in the providing of patient or resident care services. The provider shall certify on all financial reports that costs not related to patient or resident care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care throughout the state. The office may request satisfactory documentation from providers whose costs do not appear to be accurate and allowable.

FOOTNOTE TO SECTION 10(d) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: THIS SECTION AUTHORIZES THE STATE TO COMPARE LINE ITEM, COST CENTERS OR TOTAL COSTS OF PROVIDERS WITH LIKE LEVELS OF CARE THROUGHOUT THE STATE. SUCH COMPARISONS WILL OCCUR DURING THE NORMAL DESK REVIEW AND AUDIT PROCESSES. THIS ACTIVITY NATURALLY REQUIRES THE USE OF PROFESSIONAL JUDGMENT. COSTS THAT APPEAR TO BE OUT OF LINE WITH PROVIDERS WITH LIKE LEVELS OF CARE WILL BE QUESTIONED IN MUCH THE SAME WAY THAT COSTS ARE QUESTIONED UNDER THE CURRENT APPROVED PLAN. SPECIFYING THE PRECISE CONDITIONS WHEN THESE ACTIONS MUST OCCUR IS NOT FEASIBLE.

(e) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. ***(Office of the Secretary of Family and Social Services; 405 IAC 1-12-10)***

405 IAC 1-12-11 Allowable costs; services provided by parties related to provider

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

FOOTNOTE TO SECTION 11(a) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: WHEN PROVIDERS HAVE TRANSACTIONS WITH RELATED PARTIES, THE RULE REQUIRES THE RELATED PARTY'S COSTS TO BE RECOGNIZED INSTEAD OF THE COST TO THE PROVIDER. THIS IS CONSISTENT WITH LONG STANDING MEDICARE COST PRINCIPLES. THIS SECTION OF THE RULE IRRESPECTIVE OF THE WORD "MAY" IS INTERPRETED SUCH THAT THE RELATED PARTY'S COSTS WILL BE RECOGNIZED IN THE ALLOWABLE COST OF THE PROVIDER, SUBJECT TO OTHER LIMITATIONS AND PARAMETERS CONTAINED IN THE ENTIRE BODY OF THE RULE.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

(4) Stepparent, stepchild, stepsister, and stepbrother.

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.

(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.

(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient or resident care ordinarily furnished directly to patients or residents by such institutions.

(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-11)